DENTAL BULLETIN
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RATE INCREASES FOR STATE FISCAL YEAR 2001

The 91st Missouri General Assembly approved an appropriation to increase rates for dental services. The procedure codes and the new reimbursement rates are listed in this bulletin.

All of the fee-for-service rate increases are effective for dates of service on and after July 1, 2000. Fee-for-service claims that adjudicate prior to the completion of the system updates will be mass adjusted by the Division of Medical Services on a future remittance advice. Providers will be reimbursed the lower of their billed charge or the Medicaid Maximum Allowable. Managed care plans will implement a corresponding rate increase on a prospective basis later this year.

The Medicaid Maximum Allowable does not include any cost sharing or co-insurance amounts.

Procedure Code	Description	Age	Maximum Allowable Amount
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services	0-125	$12.00
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.	0-125	$36.00
99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	0-125	$36.00
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	0-125	$36.00

Procedure Code	Description	Age	Maximum Allowable Amount
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making this is straightforward or of low complexity.	0-125	$36.00
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity.	0-125	$36.00
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity.	0-125	$36.00
99241	Office consultation for a new or established patient, which requires these three components: a problem focused history; a problem focused examination; and straightforward medical decision making.	0-125	$36.00
99251	Initial inpatient consultation for a new or established patient, which requires these three components: a problem focused history; a problem focused examination; and straightforward medical decision making.	0-125	$20.00
99261	Follow-up inpatient consultation for an established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity.	0-125	$36.00

Procedure Code	Description	Age	Maximum Allowable Amount
99262	Follow-up inpatient consultation for an established patient, which requires at least two of these three components: an expanded problem focused interval history; and expanded problem focused examination; medical decision making of moderate complexity.	0-125	$36.00
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.	0-125	$36.00
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making.	0-125	$36.00
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity	0-125	$36.00
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity.	0-125	$36.00

Procedure Code	Description	Age	Maximum Allowable Amount
99311	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity.	0-125	$12.00
99312	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making or of moderate complexity.	0-125	$15.00
99331	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity.	0-125	$10.00
99332	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity.	0-125	$12.00
D0230	Intraoral-periapical each film	0-125	$5.00
D0270	Bitewing-single film	21-125	$5.00
D0272	Bitewings-two films	21-125	$9.00
D0330	Panoramic film	0-125	$26.00
D0340	Cephalometric film	0-20	$26.00

D0350	Oral/facial images(includes intra and extraoral images)	0-20	$13.00
Procedure Code	**Description**	**Age**	**Maximum Allowable Amount**
D1110	Prophylaxis-Adult	13-125	$20.00
D1204	Topical application of fluoride (prophylaxis not included)-adult	21-125	$8.00
D1510	Space maintainer-fixed-unilateral	0-20	$67.00
D1515	Space maintainer-fixed-bilateral	0-125	$100.00
D1550	Recementation of space maintainer	0-125	$16.00
D2110	Amalgam-one surface, primary	0-125	$23.00
D2120	Amalgam-two surfaces, primary	0-125	$33.00
D2130	Amalgam-three surfaces, primary	21-125	$36.00
D2131	Amalgam-four or more surfaces, primary	21-125	$36.00
D2140	Amalgam-one surface, permanent	4-125	$26.00
D2150	Amalgam-two surfaces, permanent	4-125	$33.00
D2160	Amalgam-three surfaces, permanent	21-125	$40.00
D2161	Amalgam-four surfaces, permanent	5-125	$48.50
D2330	Resin-based composite-one surface, anterior	0-125	$32.00
D2331	Resin-based composite-two surfaces, anterior	0-125	$40.00
D2332	Resin-based composite-three surfaces, anterior	0-125	$49.00
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	0-125	$59.00
D2380	Resin-based composite-one surface, posterior-primary	0-125	$32.50
D2381	Resin-based composite-two surfaces, posterior-primary	0-125	$40.00
D2382	Resin-based composite-three or more surfaces, posterior-primary	0-125	$49.00

D2385	Resin-based composite-one surface, permanent	0-125	$35.00
D2386	Resin-based composite-two surfaces, posterior-permanent	0-125	$48.00
Procedure Code	**Description**	**Age**	**Maximum Allowable Amount**
D2387	Resin-based composite-three surfaces, posterior-permanent	0-125	$60.00
D2910	Recement inlay	0-125	$21.00
D2920	Recement crown	0-125	$21.00
D2930	Prefabricated stainless steel crown-primary tooth	21-125	$60.00
D2931	Prefabricated stainless steel crown-permanent tooth	5-125	$69.00
D2932	Prefabricated resin crown	0-125	$69.00
D2940	Sedative filling	0-125	$16.00
D2951	Pin retention-per tooth, in addition to restoration	0-125	$34.00
D3220	Therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal to the denticocemental junction and application of medicament	0-125	$36.00
D3310	Root canal-Anterior (excluding final restoration)	0-125	$145.00
D3320	Root canal-Bicuspid (excluding final restoration)	0-125	$175.00
D3330	Root canal-Molar (excluding final restoration)	0-125	$222.00
D3410	Apicoectomy/periradicular surgery-anterior	1-125	$119.00
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	1-125	$119.00
D3425	Apicoectomy/periradicular surgery-molar (first root)	1-125	$119.00
D4210	Gingivectomy or Gingivoplasty-per quadrant	5-125	$127.00
D5110	Complete denture-maxillary	0-125	$357.00
D5120	Complete denture-mandibular	0-125	$355.00
D5130	Immediate denture-maxillary	0-125	$361.00

D5140	Immediate denture-mandibular	0-125	$360.00
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	8-125	$272.00
Procedure Code	**Description**	**Age**	**Maximum Allowable Amount**
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	8-125	$276.00
D5510	Repair broken complete denture base	0-125	$44.00
D5520	Replace missing or broken teeth-complete denture (each tooth)	0-125	$35.00
D5610	Repair resin denture base	0-125	$41.00
D5630	Repair or replace broken clasp	0-125	$56.00
D5640	Replace broken teeth-per tooth	0-125	$36.00
D5650	Add tooth to existing partial denture	0-125	$47.00
D5660	Add clasp to existing partial denture	0-125	$61.00
D5710	Rebase complete maxillary denture	0-125	$133.00
D5720	Rebase maxillary partial denture	0-125	$183.00
D5721	Rebase mandibular partial denture	0-125	$133.00
D5730	Reline complete maxillary denture (chairside)	5-125	$78.00
D5731	Reline complete mandibular denture (chairside)	5-125	$78.00
D5740	Reline maxillary partial denture (chairside)	5-125	$78.00
D5741	Reline mandibular partial denture (chairside)	5-125	$78.00
D5750	Reline complete maxillary denture (laboratory)	5-125	$108.00
D5751	Reline complete mandibular denture (laboratory)	5-125	$108.00
D5760	Reline maxillary partial denture (laboratory)	5-125	$108.00
D5761	Reline mandibular partial denture (laboratory)	5-125	$108.00

D5820	Interim partial denture (maxillary)	0-125	$170.00
D5821	Interim partial denture (mandibular)	8-125	$170.00
D6930	Recement fixed partial denture	0-125	$30.00
D7110	Extraction, single tooth	0-125	$31.00
Procedure Code	**Description**	**Age**	**Maximum Allowable Amount**
D7120	Extraction, each additional tooth-(To be reported for an additional extraction in the same quadrant at the same visit).	0-125	$29.00
D7220	Removal of impacted tooth-soft tissue	0-125	$66.00
D7230	Removal of impacted tooth-partially bony	0-125	$83.00
D7240	Removal of impacted tooth-completely bony	0-125	$102.00
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	0-125	$116.00
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	0-20	$61.00
D7310	Alveoloplasty in conjunction with extractions-per quadrant	0-125	$58.00
D7320	Alveoloplasty not in conjunction with extractions-per quadrant	0-125	$78.00
D9110	Palliative (emergency) treatment of dental pain-minor procedure	0-125	$16.00
D9220	General anesthesia-first 30 minutes	1-125	$82.50
Y1352	Dental Sealants (Second tooth per quadrant)	5-20	$14.00

DENTAL PROGRAM MANUAL

The Dental Manual is now available on the Internet through the DMS site at "http://www.dss.state.mo.us/dms". The On-line Dental Manual replaces the previously printed manual and associated bulletins.

Provider manuals are updated regularly. The Updated Manual List option on the manuals web site shows General Sections and manuals that have been revised. Updates are completed on a regular basis and should be checked monthly.

REPORTING MISSED DENTAL APPOINTMENTS

Providers may now report a broken appointment to the Division of Medical Services with procedure code DNKAS (Did Not Keep Appointment for Service. Code DNKAS is for reporting purposes only to enable the Division to gather data on the incidence of broken dental appointments. Only report incidents where the patient or another individual did not contact the office in advance to cancel the appointment.

The billed amount for Procedure Code DNKAS on Field 59 (Fee) must be the usual and customary charge for a missed appointment or a minimum of $1.00 as the field cannot be left blank. Claims with a DNKAS Procedure Code will show a $0.00 allowed amount on the Providers Remittance Advice. Providers will not be reimbursed for broken appointments and may not bill the recipient.

DENTURES

Full/Partial Dentures

Effective immediately, Prior Authorization (PA) is no longer required for the first set of full or partial dentures following absorption.

Replacement dentures use the same procedure codes (D5110, D5120, D5211, and D5212) as the initial set following absorption, however the providers must continue to submit a PA for replacement full and partial dentures. In the case where a recipient presents without any dentures, it is the providers responsibility to verify that the Division of Medical Services has not previously paid for a set of dentures for the recipient. If the recipient's file shows dentures were previously reimbursed, the claim for dentures will be denied if a prior authorization has not been given. Refer to section 13.33 of the Dental Manual for current replacement policy.

Interim Dentures

Effective immediately, a PA is no longer required for interim partial dentures (D5820 and D5821). The interim partial D5820 must contain at least one of the following teeth numbers: 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15. The interim partial D5821 must contain at least one of the following teeth numbers: 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31. The W5, W6, and W9 modifiers are no longer required for either code D5820, or D5821.

Interim partials are limited to once in a lifetime. In the case where a recipient presents without an interim partial, it is the providers responsibility to verify that the Division of Medical Services has not previously paid for an interim partial for the recipient. If the recipient's file shows an interim partial was previously reimbursed, the claim for an interim partial will be denied. Providers should not submit a PA request for an interim partial as the request will be denied.

When billing for interim partials the tooth/teeth number(s) being replaced must be shown in Field 59 (Description) on the claim form.

Providers may call the Provider Communication Unit at (800)392-0938 or (573)751-2896 to verify prior reimbursement of all denture procedure codes.

EXTRACTIONS

Effective for dates of service on or after July 1, 2000, procedure codes D7710YG, D7110W5, D7110W5YG, and procedure codes D7710YG, D7110W5, D7110W5YG, are no longer covered. Providers are no longer be required to use modifiers for extraction procedure codes D7110 (Extraction of single tooth) and D7120 (Extraction, additional tooth).

When billing procedure codes D7110 and D7120 a tooth number is required, however the Medicaid Maximum Allowable Amount is no longer different for a primary or a permanent tooth, regardless of the age of the individual. There is a slight differential in the Medicaid Maximum Allowable Amount between the first tooth(D7110) and each additional tooth (D7120).

YG MODIFIERS TO PROCEDURE CODES NO LONGER REQUIRED

Effective immediately, Medicaid no longer requires the provider to include the YG modifier when filing dental claims, either electronically or on paper. The YG modifier is no longer required when completing a PA form. The YG modifier will be autoplugged, when appropriate, during claims processing and will appear on the providers remittance advice.

TOOTH NUMBER 33 NO LONGER REQUIRED FOR PAPER CLAIMS

Effective immediately when filing **paper** claims the following procedure codes do not require tooth number 33 in Field 59 (Tooth): 99201, 99202, 99203, 99211, 99212, 99213, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99251, 99252, 99261, 99262, 99281, 99282, 99283, 99284, 99302, 99303, 99311, 99312, 99321, 99322, 99331, 99332, D0210, D0270, D0272, D0290, D0310, D0330, D0340, D0350, D0415, D0460, D0470, D0471, D1110, D1120, D1203, D1204, D1550, D4915, D5110, D5120, D5130, D5140, D5211, D5212, D5410, D5411, D5421, D5422, D5510, D5520, D5610, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5730,

D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5850, D5851, D5860, D7130, D8010, D8020, D8030, D8040, D8070, D8080, D8090, D8110, D8120, D8210, D8220, D8360, D8370, D8460, D8470, D8480, D8560, D8570, D8580, D8650, D8660, D8670, D8680, D8690, D8999, D9212, D9220, D9240, D9241, D9242, D9248, D9610, D9910, D9911, D9940, D9951, D9999.

A tooth number is always required for **electronic** claims submission.

DENTAL SEALANTS

Section 13.44 of the Dental Manual states sealants may only be applied on healthy (without restorations) first and second molars. The following clarifies the sealant policy regarding restoration: sealants may be applied only on the occlusal surface of first and second permanent molars (tooth numbers 2, 3, 14, 15,18,19,30 and 31) which have not had the *occlusal surface restored*.

Medicaid covers pit and fissure sealants for all eligible recipients ages 5 through 20 except for recipients with ME Codes 76-79.

PRIOR AUTHORIZATION REMOVED FOR CHILDREN

Effective immediately, the PA requirement is being removed for the following services.

- Procedure code D2950 (core buildup, including any pins)
- Procedure code D2952 (cast post and core in addition to crown)
- Procedure code D4381 (localized delivery of chemotherapeutic agents via controlled release vehicle into diseased crevicular tissue, per tooth)
- Procedure code D4920 (unscheduled dressing change by someone other than treating dentist)

PROPHYLAXIS

Effective for dates of service on or after July 1, 2000, modifiers W5 and W6 are no longer required to identify the upper or lower arch. Providers should bill the appropriate adult or child prophylaxis procedure code. Procedure code D1110 (Prophylaxis - adult-both arches) and D1120 (Prophylaxis-child-both arches) are only payable in six month intervals. If a prophylaxis is needed more often than every six months , a dental provider may bill using procedure code D9999 on a paper claim. The provider must attach a completed Certificate of Medical Necessity form explaining why the service was performed.

INTRAORAL X-RAYS

Effective for dates of service on or after July 1, 2000, the W5 modifier has been removed from D0210 (Intraoral complete including bitewings). Bitewing procedure codes D0270, D0272 and D0274 can not be billed on the same date of service as procedure code D0210.

SIALOGRAPHY

Effective for dates of service on or after July 1, 2000, the W5 modifier is no longer required when billing the injection for sialography. Procedure code D0310 now includes the injectable material cost. The Medicaid Maximum Allowable for a sialography has been changed to include the amount allowed when the modifier was used.

SALTZMANN'S HANDICAPPING MALOCCLUSION ASSESSMENT FORM NO LONGER REQUIRED

Effective immediately, the Handicapping Malocclusion Assessment Form is no longer required when requesting prior authorization for orthodontic treatment. The Medicaid orthodontic consultant will determine the recipient's total points and the medical necessity of the requested orthodontic treatment per the orthodontic guidelines as stated in Section 13.38A of the Dental Manual. When requesting prior authorization for orthodontic services, the provider must complete and submit the Prior Authorization Request form together with complete diagnostic orthodontic records including x-rays, study models, and a written treatment plan. Reference section 13.48 for description of orthodontic records.

REPLACEMENT ORTHODONTIC PROCEDURE CODES

In order to be consistent with the American Dental Association CDT-3 Users Manual, the following procedure codes are being added as replacement codes to the Dental Program effective August 1, 2000. On or after this date, providers must use the new codes when requesting prior authorization. All codes other than D8210 are limited to recipients age 0-20, except for recipients with ME codes 76-79.

Procedure Code	Description
D8010	Limited orthodontic treatment of the primary dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*
D8020	Limited orthodontic treatment of the primary dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*
D8030	Limited orthodontic treatment of the adolescent dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*
D8040	Limited orthodontic treatment of the adolescent dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*

D8050 Interceptive orthodontic treatment of the primary dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*

D8060 Interceptive orthodontic treatment of the adult dentition. Prior authorization required. *Only authorized for the treatment of cleft palate or other facial abnormality.*

D8070 Comprehensive orthodontic treatment of the transitional dentition. Prior authorization required.

D8080 Comprehensive orthodontic treatment of the adolescent dentition. Prior authorization required.

D8090 Comprehensive orthodontic treatment of the adult dentition. Prior authorization required.

D8210 Removable appliance therapy. (Adult and child)

D8660 Pre-orthodontic treatment visit - *This will be used by a dentist if the child came to see him and regular orthodontic treatment was not recommended at the time.*

D8670 Periodic orthodontic treatment (as part of a contract) - *This will be used to bill the quarterly payments.* Prior authorization required.

D8680 Orthodontic retention (Removal of appliances, construction and placement of retainers.) - This will be used for recipients who are in orthodontic treatment when they become eligible for Medicaid and would have met Missouri Medicaid's guidelines for orthodontic treatment. Prior authorization is required.. Send the original study models, x-rays and photographs prepared prior to the orthodontic treatment with the prior authorization request. Prior authorization required.

ORTHODONTIC PROCEDURE CODES BEING REPLACED

The following orthodontic procedure codes are no longer valid CDT-3 codes and are being replaced by current codes. If providers have an approved prior authorization for the procedure codes which are being replaced, the procedure codes shown on the approved prior authorization must be billed when the service is provided.

Procedure Code Being Replaced	Description	Replacement Codes (See previous section for description)
D8110	Removable appliance therapy	D8210
D8110YG	Removable appliance therapy	D8210
D8110W5	Removable appliance therapy	D8210
D8120	Fixed appliance therapy-cross-bite appliance, posterior, two bands, and attachments	D8210

D8360YG	Removable appliance therapy	D8010, D8020, D8030, D8040, D8050, D8060
Procedure Code Being Replaced	**Description**	**Replacement Codes (See previous section for description)**
D8370	Fixed appliance therapy-cross-bite appliance, posterior, two bands, and attachments	D8010, D8020, D8030, D8040, D8050, D8060
D8460YG	Class I malocclusion	D8070, D8080, D8090
D8470YG	Class II malocclusion	D8070, D8080, D8090
D8480YG	Class III malocclusion	D8070, D8080, D8090
D8560YG	Class I malocclusion	D8070, D8080, D8090
D8570YG	Class II malocclusion	D8070, D8080, D8090
D8580YG	Class III malocclusion	D8070, D8080, D8090
D8650YG	Treatment of atypical or extended skeletal case	D8070, D8080, D8090

BILLING HINTS

Every month the Dental Program receives a report from GTE Data Services which lists the top reasons dental claims are denied. Following are some billing hints to help providers correct these errors.

- Make sure Field 56 (Is treatment result of occupational illness or injury?.....) and Field 57 (Is treatment result of .....) are completed on the dental claim form. Claims will auto deny if these fields are not completed.

- Make sure the procedure code shown on the claim form is a current code recognized by the Dental Program.

- Make sure Fields 19 - 41 are left blank if the recipient does not have any other commercial dental insurance. Do ***not*** put Medicaid or Medicare information in any of these fields. If the recipient does not have other commercial dental insurance and the provider has put information in any of these fields, the claim will deny for other insurance information.

- Field 59 (Date-MM/DD/YYYY) must have the date the service was provided to the recipient. If this date is missing, the claim will deny.

- Providers should verify the recipient's eligibility prior to providing services. During April 2000, 8.38% of fee-for-service dental claims denied because of recipient eligibility issues. The recipients were not eligible for fee-for-service services because the recipients were in MC+ Health Plans or the recipients were in ME codes 76, 77, 78, or 79 which do not have dental benefits except for the treatment of disease or trauma.

CORRECTION TO SPECIAL BULLETIN DATED MAY 1, 2000

Special Bulletin, Volume 22, No. 6 dated May 1, 2000, page 7 is corrected as follows: procedure code D4280 is deleted. The correct procedure code is D2780 (Crown - 3/4 cast high noble metal).

MANAGED CARE INFORMATION

MC+ refers to the statewide medical assistance program for low income pregnant women, parents transitioning from welfare to work, children, and uninsured parents. MC+ recipients receive their care either through the fee-for-service delivery system or the managed care delivery system depending upon their county of residence. MC+ for Kids is a subgroup of MC+ and refers to Missouri's State Children's Health Insurance Program (SCHIP). Medicaid refers to the fee-for-service program for elderly and disabled individuals.

All providers who have an approved Medicaid provider enrollment agreement are automatically considered MC+ providers for any eligible individual who is not locked into managed care health plan. Some individuals receive a limited benefit package and are not eligible for certain services. Please refer to your Medicaid provider manual for more information.

The policy changes in this bulletin apply to the MC+ and Medicaid fee-for-service program only. MC+ managed care plans will be implementing a dental rate increase later this year. If you contract with MC+ managed care plans or a dental plan subcontractor you will receive more information about rate increases from the plan later.

Responses to a request for proposals for managed care contracts for the Eastern MC+ Managed Care Region are currently being prepared by bidders. Five new counties will be included in the Eastern MC+ Managed Care region, effective December 10, 2000. Those counties are St. Francois, Ste. Genevieve, Lincoln, Warren and Washington.

PLANNED ENHANCEMENTS TO THE DENTAL PROGRAM

The Division of Medical Services is planning more enhancements to policy and billing procedures that will enable dentists to furnish and bill for services for MC+ and Medicaid patients in ways comparable to private practice and will be announcing those updates in future bulletins.